

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space:

27363

1. PLACE OF DEATH

County Jackson Registration District No. 599
 Township Wau Primary Registration District No. 1007
 City Kansas City (No. 5702 Locust St) St. _____ Ward _____

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Mrs Frances Payne Hunt
 (a) Residence, No. 5702 Locust St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
 (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 11-1893
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 | 5 | 10

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Louise
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Marion Payne
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Va
 12. MAIDEN NAME OF MOTHER Ella Oliver
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

14. INFORMANT Mrs Anna Belle Glenn (Address) Crick mo.

15. FILED 9/22-27 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1927
 17. I HEREBY CERTIFY, That I attended deceased from Aug 1-1927 to Sept 21-1927 that I last saw him alive on 9-20-1927, and that death occurred, on the date stated above, at 7 a.m. in _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
31 (duration) 1 1/2 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED do not know
 IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Sputum
 (Signed) Frank H. Lobe M. D.
9-21-1927 (Address) Kansas City, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lawson, Mo. DATE OF BURIAL 9/23/27

20. UNDERTAKER The Freeman Mortuary ADDRESS Baltimore An.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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